

TREATMENT OF RETAINED PLACENTA IN PRESENCE OF SEPSIS AND EXSANGUINATION

BY

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In the present age there has been a change of conception regarding the management of the third stage of labour, as well as of the complications arising thereof. More emphasis is being given to the prevention of post-partum haemorrhage. An attitude of 'masterly inactivity' and 'watchful expectancy' in the management of the third stage of labour has definitely helped in the maintenance of normality. Use of oxytocic drugs towards the end of the second stage of labour has proved to be of useful prophylactic value. Flew, Lister, Martin and others have recorded their observation about their efficacy. The author has used them as a routine in all cases where post-partum haemorrhage was apprehended. These cases include difficult forceps applications, ante-partum haemorrhage, hydramnios, plural pregnancy and large sized babies. Ergometrine, 0.25 mgm., was used intravenously with the delivery of the head. In some of the cases the length of the third stage was markedly reduced, practically in all, the post-partum loss was markedly reduced. None of

the cases necessitated manual removal of placenta. Routine administration of ergometrine after the expulsion of the placenta has proved to be an additional safeguard against atonic post-partum haemorrhage. The operation of manual removal of placenta is no longer viewed with the same apprehension and fear as it was. It is now recognised that, carried out at the proper time, it is not a difficult or dangerous operation and it is definitely life saving. In the presence of post-partum haemorrhage Greenhill advocates a forthwith manual removal of placenta under anaesthesia, in preference to the Crede method of expression of placenta, which often fails and is always associated with risks of traumatising the uterus and causing severe obstetric shock. This attitude has been made possible with the introduction of efficient antibiotic and chemotherapeutic agents, blood transfusion, and the more advanced methods of anaesthesia. Though the operation is quite safe if carried out at the optimal time, many cases are only seen when any operative procedure would be extremely dangerous. It is the management of these cases that requires a careful judgment and experience. Strangely

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was performed under open ether anaesthesia. No constriction ring was encountered. The puerperium was afebrile.

The third group of cases where profound collapse and shock had followed excessive blood loss are definitely unsuitable for manual removal of placenta without adoption of resuscitative measures to restore the loss of blood and combat the shock. In some of these cases the placenta may spontaneously separate, the others may require manual removal.

The fourth group of cases are those which are confined outside and are brought to hospital in an exsanguinated condition due to blood loss. Very often the placenta is retained for hours with signs of frank infection. In these cases a conservative line of treatment is adopted.

1. Loss of blood is replenished by blood transfusion.
2. Infusion of glucose saline and plasma substitute is given in addition, to counteract haemoconcentration and loss of electrolytes.
3. Penicillin and streptomycine are injected for sepsis.
4. Sulpha group of drugs are given orally.
5. Nourishment is maintained by milk, fruit juices and wherever possible by full diet.
6. Manual removal is not undertaken until the general condition improves and the patient becomes completely afebrile.

The author has been practising this line of treatment for several years. Time does not permit a detailed presentation of cases. It is be-

lieved that similar practice is adopted in other maternity centres in India as well, and the experience of other workers is likely to be identical. Manual removal after restorative treatment, when the patient is afebrile makes the operation completely safe and prevents dissemination of infection which would otherwise have resulted had it been done at an earlier stage.

Case 1. Mrs. A., age 30 years, 8th gravida, delivered of a live baby at full term at 9 a.m. on 2-10-1954 in a tea estate several miles away. She had a severe P.P.H. and was admitted to Assam Medical College Hospital at 5-45 p.m. on 2nd October 1954.

Condition on admission: marked pallor, pulse 132 p.m., low volume and tension, respiration 26 p.m., Hb. 40 per cent. placenta not separated, slight bleeding continuing. 0.25 mgm. of ergometrine injected I.V., morphine gr. $\frac{1}{4}$ hypodermically, 500 c.c. Bayer's periston given I.V., crystalline penicillin 50,000 units 4 hourly. At 11 p.m. blood was available and 350 c.c. was transfused.

On 3-10-1954, pulse 94 p.m., B.P. 104/60 mm., temp. 102.4°F., 360 c.c. blood transfused.

On 4-10-1954, pulse 128 p.m., volume and tension moderate, temp. 101°F. The placenta was spontaneously expelled at 2-30 p.m.

Temperature dropped to normal and remained under control from 5-10-1954.

Case 2. Mrs. P.G., age 35 years, 13th para, was admitted to Assam Medical College Hospital on 2nd October 1954 in the following condition. Labour pains started at home on 26-9-1954. Membranes ruptured

on 27-9-1954. Head was born on her way to hospital where she was admitted at 9-30 p.m. on 2nd October 1954. Patient was looking extremely exhausted, pulse 96 p.m., temp. 101°F, bladder was distended, rising upto 2" below umbilicus, marked dextrodeviation of uterus. Head was born but the rest of the body was retained. Uterine contraction of moderate intensity. Patient was catheterised on admission. 500 c.c. of 5 per cent glucose saline was given.

A vaginal examination revealed that the posterior shoulder was lying low in vagina. It was released gently. With the next 2 or 3 contractions the baby was born. With the birth of the baby there was sudden vaginal bleeding. Ergometrine 0.25 mgm. I.V. controlled the bleeding. Penicillin injections 50,000 units every 4 hrs. were started.

3-10-1954. No vaginal bleeding, pulse 112 p.m., temp. 101°F. Condition improved in course of the day. Placenta separated spontaneously without further blood loss and could be expressed at 5-5 p.m.

Case 3. Mrs. B.G., age 35 years, 9th gravida, delivered at home at full-term of a live female baby at 6 p.m. on 27-12-1954 and had P.P.H. after delivery. She was admitted to Assam Medical College Hospital on 28th December 1954 at 12-30 p.m. with placenta retained.

Condition on admission: Extremely anaemic, Hb: 35 per cent, pulse 120 p.m., volume and tension low, temp. 99°F. Placenta retained—200 c.c. of blood transfusion was followed by 500 c.c. of 5 per cent dextrose saline. Penicillin 50,000 units given every 3 hrs.

29-12-1954. 350 c.c. of blood by transfusion at 11-30 a.m. Condition improved. Manual removal of placenta at 2 p.m. Patient had a rise of temperature upto 102°F. on 30th December 1954 but it was controlled with penicillin injections and Elkosin 2 tablets 4 hrly. given orally.

Case 4. Mrs. A, age 28 years, 3rd preg. Delivered of a live baby in a tea estate at 3 p.m. on 29-11-1954. Had post-partum haemorrhage. She was brought to Assam Medical College Hospital on 30th November 1954 at 1-30 p.m.

Condition on admission: Pulse 140 p.m., BP—110/80, Hb. 45 per cent, 500 c.c. of dextrose saline on admission.

Penicillin 50,000 units I.M. every 3 hrs. Elkosin—2 tablets every 4 hrs. 350 c.c. of blood by transfusion at 8-15 p.m. Temp. 101°F. Placenta separated spontaneously at 4-30 a.m. on 1-12-1954.

Case 5. Mrs. S., age 32 years, 6th para. Admitted to Assam Medical College Hospital on 18-12-1954 at 8-15 a.m. She was confined outside in a tea estate at 1 a.m. Placenta was retained. Pulse 100 p.m. Vol. and tension low. Hb: 45 per cent, B.P. 86/50 mm. Pallor marked, temp. 101.5°F.

From 19-12-1954 a daily rise of temperature upto 102°F. was recorded. Blood transfusion 350 c.c. and 500 c.c. of 5 per cent dextrose saline. Penicillin 50,000 units every 3 hrs. Elkosin—2 tablets every 4 hrs. Pyrexia controlled on 26-12-1954. Manual removal of placenta 27th December 1954. Apyrexia followed manual removal.

Discussion

Considerable discussion has centred round the question of administration of oxytocic drugs before the delivery of the placenta. Berry Hart strongly advocated it. He recommended the use of ergotin by injection in all cases after the head is born and said one should not wait for haemorrhage before injecting it.

Flew administered in 500 cases of normal labour 0.5 mgm. of ergometrine intramuscularly as soon as the head was delivered. In no case did he observe a constriction ring and in no case was manual removal of placenta necessary.

Shaw states that its use in abnormal third stage is safe and effective. It controls the haemorrhage in retained placenta, diminishes the need for transfusion and reduces the incidence of manual removal of placenta.

Linton Snaith states that the administration of ergometrine will not separate an abnormally adherent placenta but will diminish blood loss under such conditions. He further states that it does not make the operation of manual removal of placenta any more difficult if it should become necessary.

Martin and others observe that the use of ergometrine intravenously strikingly reduced blood loss in the third stage and lowered the rate of primary post-partum haemorrhage. Manual removal rate was slightly increased.

Munro Kerr and Moir make the following observation: "If the cause of haemorrhage is a retained placenta and if the uterus is flabby and is re-

sisting stimulation by kneading, ergometrine injected intravenously or preferably pitocin (5 units) injected directly into the musculature of uterine body brings about a powerful contraction which greatly aids any effort at expulsion of placenta. If, however, the obstetrician fails to expel the placenta, something at least is gained, for the uterus is now tightly contracted and the haemorrhage temporarily arrested." These observations as well as personal experiences have convinced the author that the administration of oxytocics before the delivery of the placenta would do no harm, on the contrary is an effective weapon in the armamentarium for checking the bleeding immediately. In the maternity hospitals it is the young inexperienced house-surgeons who are called to see cases of post-partum haemorrhage in the first instance. What should he do? He will probably overdo Crede's expression. He has no previous experience of manual removal. The author believes that under such circumstances intravenous ergometrine will immediately control bleeding and manual removal, if required, can be done by the seniors after adequate restorative methods.

Case I of the author's series clearly illustrates this type. Macafee has also very strongly advocated the above treatment. The shocked and collapsed patients require restorative treatment in the first instance.

Sheehan in his paper "Shock in Obstetrics" directed attention to the "menace of placenta left too long in utero" and he believes that shock can be caused by a retained placenta

even in the absence of bleeding or in attempts at manual expression. With this view Browne is not in agreement. The author believes that all obstetricians are against manual removal unless the existing shock and blood loss have been combated. Unfortunately in the practice of most maternity hospitals in India the issue is further complicated by the presence of sepsis. In these cases should placenta be removed after blood loss has been replenished irrespective of presence of sepsis or should it be done after sepsis has been controlled?

The author has always preferred to treat sepsis first. The cases presented have illustrated that in some placenta separated spontaneously, whereas in others manual removal was a completely safe procedure.

It is apparent that many maternity centres adopt the line of treatment advocated by the author but it does not appear that anyone has documented his experience or results with this form of treatment. It is

the purpose of this presentation to elicit opinion on the subject and recommend its adoption in the obstetric practice of the Indian hospitals.

References

1. Flew J.D.S. : Pro. R. Soc. Med. ; 40, 370, 1947.
2. Greenhill J.P. : The Year Book of Obst. & Gynae. ; Chicago, The Year Book Publishers, 1953-54.
3. Hart D. Berry : Guide to Midwifery ; London, Heinemann, 1912.
4. Lister. : J. Obst. & Gyn. B.E., 57, 210, 1950.
5. Macafee : Modern Trends in Obst. and Gynae. ; London, Butterworth, 1950.
6. Martin and others : B.M.J.I. ; March 21, 643, 1953.
7. Munro Kerr J.M. & Moir J. : Operative Obstetrics ; London, Balliere Tindall & Co., 1949.
8. Shaw D.A.F. : J. Obst. & Gyn. B.E. ; 56, 833, 1949.
9. Sheehan H.L. : Lancet ; 1, 1, 1948.
10. Snaith Linton : J. Obst. & Gyn. B.E. ; 58, 633, 1951.